**How We Doctors Are Failing Our Patients Who Drink Too Much**

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By Dr. Elisabeth Poorman

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The middle-aged man in my exam room wasn’t an alcoholic. At least, that’s what he declared to me as I asked him questions about his drinking. "I’m not like *those* people," he said, smiling nervously. "I go to work. I don’t fall down the stairs. I don’t embarrass myself."

As we spoke further about the consequences of drinking six to seven beers every night (and a few shots here and there), he kept pushing back. “I just need to relax. I’m stressed at work and at home. Money’s tight. I’m like everybody else. I’m normal."

As the [fourth-leading cause of preventable death](https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics), killing an estimated 88,000 Americans a year, alcohol is the most common problem that I encounter as a primary care doctor, and the one that I feel least able to manage. My ineffectiveness is all the more frustrating as addiction deaths continue to rise, contributing to the first drop in [the American population's life expectancy](https://www.cdc.gov/nchs/products/databriefs/db267.htm) [in generations](http://www.npr.org/sections/health-shots/2017/03/23/521083335/the-forces-driving-middle-aged-white-peoples-deaths-of-despair).

With all of our incredible medical advances, we have utterly failed to combat the growing plague of addiction. And while opioid disorders are gaining more attention, alcohol still [kills more people](http://www.drugwarfacts.org/cms/Causes_of_Death) than all illicit drugs combined.

In researching this problem and speaking to experts across the country, I’ve realized that we as a medical community do not take unhealthy alcohol use as seriously as we should. This is maddening. We have treatment that works, is cost-effective and saves lives; but our patients aren’t getting it. When it comes to alcohol, we are under-trained, under-supported and underfunded. As a result, we have failed to address unhealthy alcohol use in any meaningful way.

The first obstacle we have to face is a fundamental misunderstanding of the problem itself.

**An Alcoholic By Any Other Name**

Let me start by saying I am not talking about “alcoholism.” The reason I’m not talking about alcoholism is because that is not a medical diagnosis. More importantly, it promotes stereotypes about how an alcoholic looks and behaves. These stereotypes keep patients from admitting they have a problem, and keep providers from asking about or recognizing their symptoms.

Some find the word "alcoholic" helpful in their recovery, to remind themselves that they cannot control their drinking. But it is not a word that clinicians should use, according to Mark Albanese, director of Adult Outpatient Addiction Services at Cambridge Health Alliance. It promotes the idea that people fit into neat boxes, with only a few needing further treatment and support.

When I began medical school, this categorical thinking was perpetuated by an unscientific classification of alcohol use in the medical community as “abuse” or “dependence” (neither of which would have characterized the man I saw in clinic).

This distinction confuses doctors and their patients, according to Anna Lembke, director of Addiction Medicine at Stanford University. Lembke and other addiction specialists welcomed the 2013 shift in medical thinking to the broader term "[alcohol use disorders](https://psmag.com/when-it-comes-to-addiction-the-dsm-5-gets-it-right-but-e3edc153182f)."

But popular advice columnists continue to promote the idea that "[joyous drinking](http://www.wbur.org/dearsugar/2016/03/11/dear-sugar-episode-forty-six)" isn’t a problem, regardless of the amount consumed, as long as the person isn’t an “alcoholic.” We in health care are not immune to these stereotypes. Indeed, our training may inadvertently promote them.

In residency, the period after medical school when our clinical decisions are still supervised, we spend the majority of our time in the hospital. The addiction we see tends to be obvious and advanced. Meanwhile, patients with less severe problems pass through our clinics and hospitals undetected.

The most important problem with this crude thinking about alcohol addiction is that we fail to see it in our patients, our friends and ourselves. The men and women I spent long nights detoxing were not born addicted to alcohol. They were you, or me, or your friend, drinking everyone under the table night after night.

Over time, their heavy drinking led to worse cravings until their addiction spiraled out of control. When we could have helped, we made excuses, or uncomfortable jokes, or looked away. Instead of offering them help, we went out the next night and offered them a drink.

Our most important tool for capturing patients with early stages of alcohol use disorders is to screen everyone. The erosion of primary care and patients’ misunderstandings about alcohol, however, makes even this simple step enormously complicated.

**How Much Is Too Much?**

Have you had four or more drinks in a single day in the last year? This is the first question that I ask patients during screening, to decide if they are drinking unhealthy levels of alcohol.

Women who have had four or more drinks in a single day or more than seven drinks a week, or men who have had five or more drinks in a single day or 14 in a single week over the past year, are somewhere on a spectrum of risky drinking. This means they are at greater risk for [a slew of health problems](https://pubs.niaaa.nih.gov/publications/Hangovers/beyondHangovers.htm), including liver disease, heart disease, diabetes, depression and high blood pressure.

If you answer yes to that first question, it doesn’t mean that you are addicted to alcohol. In fact, the majority of people who screen positive for unhealthy alcohol use will not meet criteria for addiction, says Richard Saitz, chair of the Department of Community Health Sciences at the Boston University School of Public Health.

But it does mean that you are drinking a potentially dangerous amount of alcohol. And even for people drinking below these amounts, alcohol may have negative impacts on their health, including [increasing their risks for certain cancers](http://www.webmd.com/mental-health/addiction/news/20140814/amount-alcohol#1).

And before you stop reading because you can answer no to that first question, you still may be drinking too much for your body, and you probably have no idea what a [standard drink](http://www.alcohol.org.nz/help-advice/about-standard-drinks/can-you-pour-a-standard-drink) is. (For instance, it’s commonly said that there are four “glasses” of wine in a bottle. Actually, there are [5].)

**A Glass Of Wine A Day Keeps The Doctor Away**

You may have heard the myth that moderate drinking is good for you. This has been supported by a surge in “clickbait” articles that tout the benefits of alcohol, especially red wine.

But drinking moderately is probably [much less healthy than we have been led to believe](http://www.webmd.com/mental-health/addiction/news/20140814/amount-alcohol#1). A few small studies point to a modest improvement in heart health for those who drink less than one drink a day, but it is much less convincing than headlines like “[13 Reasons You Need to Drink More Wine](http://www.news.com.au/lifestyle/health/diet/13-reasons-you-need-to-drink-more-wine/news-story/516e98b251b1745a61da2a6bdbc1e868)” would have you believe.

Drinking expensive wine is no defense against the ravages of alcohol use. I have found that for a certain socioeconomic class, this misunderstanding has provided a defense mechanism against clear evidence that drinking is affecting their health. “I’m doing the good kind of drinking,” they’ll tell me.

Even when they acknowledge their loved ones are drinking too much, they’ll use phrases like “he’s a functional alcoholic,” meaning I guess, that he still goes to work and pays his bills on time (which probably has more to do with his economic and social status than it does the severity of his addiction).

Among doctors, alcohol disorders are pervasive, and, like other mental health disorders, [under-treated](http://www.wbur.org/commonhealth/2016/08/19/depression-resident-doctor). I have heard the joke “My patient doesn’t have a problem with drinking, unless they drink more than I do,” from more than one doctor, often as he or she is heading back to the open bar. This may be one reason that only [1 in 6 patients](https://www.cdc.gov/vitalsigns/alcohol-screening-counseling/) have been asked about their drinking.

**What We Can Do, And Why We Don't**

I’m not advocating for us to throw up our hands. Our field is dominated by a fatalism about addiction treatment that is keeping us from engaging with this huge problem.

When I was a student, a prominent psychiatrist dismissed my concerns when I tried to get a patient treatment for his alcohol use. “People who want to quit drinking just quit drinking,” he told me. “They go to Alcoholics Anonymous. They don’t need treatment.”

He was wrong. And for many patients he treated and the physicians he trained, his misconceptions were probably deadly.

In the clinic, we know that brief counseling about alcohol use *can* help people drink less often and less heavily. We don’t know whether these interventions prevent the serious consequences of unhealthy alcohol use, like accidents and death, but for some people, [they probably do](https://pubs.niaaa.nih.gov/publications/arh23-2/128-137.pdf). We also have medications, especially naltrexone, that reduce heavy drinking and are [frequently under-prescribed.](https://www.nytimes.com/2014/05/14/health/effective-drugs-to-curb-alcoholism-are-ignored-study-finds.html?_r=1)

These interventions can take as little as five minutes. In a 20-minute visit, however, even this can feel like a big ask, says Steve Adelman, director of Physician Health Services for the Massachusetts Medical Society. The impossibility of providing quality care in such short visits has many providers “not wanting to ask questions that are going to take them down a rabbit hole,” he said.

There’s also a huge lack of residential beds for patients who need intensive treatment for their substance use disorders. There are 23 million people in the United States who need treatment for addiction, and only a [little over a thousand residential programs](http://wickedsober.com/category/wicked-sober-2/). As a result, except for the very motivated and lucky few, we often detox patients and send them back home or onto the street without treatment.

There are services working to connect patients to treatment, like [Wicked Sober](http://wickedsober.com/), [New England Addiction Outreach](https://www.facebook.com/NEAddictionOutreach/) and the [Student Coalition on Addiction](https://ma-sca.org/about/). Resources, however, change all the time, and it is unrealistic to expect primary care doctors without the proper training, or the time, to be able to connect patients to the best care. In clinics without social workers or other support staff, screening will yield a certain number of patients who need serious help that we don’t know how to provide.

As Lembke told me, the public may talk about addicts not getting help because they’re not motivated, but that’s not what she sees. “I see a lot of people who want help but can’t get it because they can’t find it, or insurance won’t pay for it,” she says.

If we agree that addiction is a medical disease, why are we making it so hard to get treatment? I never hand a patient with asthma a list of facilities to call, and tell her she has to wait 14 days or pay up to $30,000 out of pocket to get medication and counseling. When properly treated, [relapse rates for alcohol and asthma are similar](https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery), but one is considered a failure of character and the other is seen as the natural course of the disease.

Alcohol addiction is [one of the deadliest diseases](https://www.ncbi.nlm.nih.gov/pubmed/23627868), deadlier than most other chronic diseases such as asthma, high blood pressure or diabetes. If a patient has money, time, a place to live, insurance and a supportive community, even severe addiction may improve. Treatment works. Medication works. When people are motivated, [Alcoholics Anonymous works,](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2746426/) and it’s free.

For those who don’t have these advantages, I hope we can ask ourselves, realistically, what are we offering people with this deadly disease? How long do we expect their intrinsic motivation to overcome their own hijacked brains and propel them through every barrier we throw up?

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